

How to change your Managed Care Organization (MCO)

Federal regulations allows members to change their through a process called “Disenrollment for Cause”. This process is for members who want to change their current MCO and are not within their 90 day timeline to change. If you have questions or need help with the process, contact Member Services at (800) 635-2570 from 8 a.m. - 5 p.m. ET Monday – Friday.

1. **Before you request “Disenrollment for Cause”, contact your current MCO and discuss your issue(s).**
2. If you still are not satisfied with the answer the MCO gave you, **you must write a letter signed by you or your designee** requesting Disenrollment for Cause and **must** include the following:
 - First and Last name, Social Security Number (SSN) and/or KY Medicaid ID number of all household members that are requesting disenrollment
 - Your current address/phone number
 - The reason you are requesting disenrollment including a summary of the contact you had with their current MCO in order to resolve your issue and their response to your issue.
 - *Please include the name of your primary care physician and the hospital you use.*
 - Please provide a listing of your current prescription medication.
 - *Please include the name of the MCO you wish to be enrolled in.*

You may either fax or mail the request to:

Cabinet for Health and Family Services
Department for Medicaid Services
Managed Care Branch
275 East Main Street, 6W-A
Frankfort, KY 40621
Fax: (502) 564-0509

Please be advised this process may take up to 90 days. If you have submitted your request and have questions, please contact the Managed Care Branch at 502-564-4321.

Date: _____

To Whom It May Concern:

I, _____ (first and last name) am seeking to change my MCO outside of Open Enrollment for the following reason *(include summary of contact you had with current MCO in order to resolve your issue and their response to your issue)*

My Case#:

My Social Security Number is:

My Medicaid ID# Is:

My Mailing Address Is:

Household Member(s) requesting change in MCO: _____

My Phone Number That I Could be reached at is:

- 1) () -
- 2) () -

My Primary Care Provider is: _____

The hospital that I use is: _____

The Following is a Complete List of My Medications: (Attach Additional Sheet if Necessary)

- 1)
- 2)
- 3)
- 4)
- 5)
- 6)
- 7)
- 8)
- 9)
- 10)

The MCO that I am seeking that I feel best meets my needs is: _____
Thank you for your time as I await the results of the above MCO Change Request.

Sincerely,

_____, _____
Signature Date

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